

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0003038</u></p> <p>Facility Name: <u>Elmhurst Extended Care Center</u></p> <p>Address: <u>200 East Lake Street</u> <u>Elmhurst</u> <u>60126</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 834-4337</u> Fax # <u>(630) 834-4122</u></p> <p>IDPA ID Number: <u>362472961000</u></p> <p>Date of Initial License for Current Owners: <u>02/18/1961</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles Fischer</u> Telephone Number: <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>08/01/2004</u> to <u>07/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p style="text-align: center;">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Elmhurst Extended Care Center# 0003038 Report Period Beginning: 08/01/2004 Ending: 07/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>112</u>	Skilled (SNF)	<u>112</u>	<u>40,880</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>112</u>	TOTALS	<u>112</u>	<u>40,880</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,210</u>	<u>3,341</u>	<u>7,471</u>	<u>12,022</u>	8
9	SNF/PED					9
10	ICF	<u>1,603</u>	<u>16,310</u>		<u>17,913</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,813</u>	<u>19,651</u>	<u>7,471</u>	<u>29,935</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.23%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location

Date started 08/09/1960

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 42 and days of care provided 7,088Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year

YES ☒NO ☐Tax Year: 07/31/05 Fiscal Year: 07/31/05

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Elmhurst Extended Care Center # 0003038 Report Period Beginning: 08/01/2004 Ending: 07/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	220,093	24,374		244,467		244,467		244,467		1
2	Food Purchase		150,888		150,888		150,888		150,888		2
3	Housekeeping	169,135	27,517		196,652		196,652		196,652		3
4	Laundry	23,999	9,375		33,374		33,374	(6,450)	26,924		4
5	Heat and Other Utilities			109,409	109,409		109,409		109,409		5
6	Maintenance	41,710		130,213	171,923		171,923	(65,294)	106,629		6
7	Other (specify):*										7
8	TOTAL General Services	454,937	212,154	239,622	906,713		906,713	(71,744)	834,969		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	1,843,292	164,303	51,787	2,059,382		2,059,382		2,059,382		10
10a	Therapy	189,261	393	52,933	242,587		242,587		242,587		10a
11	Activities	69,347	1,614	442	71,403		71,403		71,403		11
12	Social Services	42,744		1,142	43,886		43,886		43,886		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,144,644	166,310	136,304	2,447,258		2,447,258		2,447,258		16
	C. General Administration										
17	Administrative	88,578			88,578		88,578		88,578		17
18	Directors Fees										18
19	Professional Services			36,660	36,660		36,660	(6,284)	30,376		19
20	Dues, Fees, Subscriptions & Promotion			19,822	19,822		19,822		19,822		20
21	Clerical & General Office Expense	236,689	17,274	11,392	265,355		265,355	260	265,615		21
22	Employee Benefits & Payroll Taxes			376,478	376,478		376,478		376,478		22
23	Inservice Training & Education										23
24	Travel and Seminars			14,052	14,052		14,052	(875)	13,177		24
25	Other Admin. Staff Transportation			5,691	5,691		5,691		5,691		25
26	Insurance-Prop.Liab.Malpractice			97,504	97,504		97,504		97,504		26
27	Other (specify):*										27
28	TOTAL General Administration	325,267	17,274	561,599	904,140		904,140	(6,899)	897,241		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,924,848	395,738	937,525	4,258,111		4,258,111	(78,643)	4,179,468		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Elmhurst Extended Care Center

#0003038

Report Period Beginning:

08/01/2004

Ending:

07/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			82,921	82,921		82,921	33,652	116,573			30
31	Amortization of Pre-Op. & Org											31
32	Interest			112,519	112,519		112,519	(5,321)	107,198			32
33	Real Estate Taxes			33,848	33,848		33,848		33,848			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle											35
36	Other (specify): ³											36
37	TOTAL Ownership			229,288	229,288		229,288	28,331	257,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:		206,432		206,432		206,432		206,432			39
40	Barber and Beauty Shops			12,870	12,870		12,870		12,870			40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify): ³ Nonallowable Costs			167,359	167,359		167,359	(167,359)				43
44	TOTAL Special Cost Centers		206,432	241,549	447,981		447,981	(167,359)	280,622			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,924,848	602,170	1,408,362	4,935,380		4,935,380	(217,671)	4,717,709			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients	(6,450)	4		8
9	Non-Straightline Depreciation	33,652	30		9
10	Interest and Other Investment Income	(5,321)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,718)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,125)	43		20
21	Owner or Key-Man Insurance	(2,417)	43		21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(75,947)	43		24
25	Fund Raising, Advertising and Promotiona	(16,671)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employee				28
29	Yellow Page Advertising	(29,268)	43		29
30	Other-Attach Schedule See attached Schedule 5A	(102,406)			30
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (217,671)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (217,671)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Elmhurst Extended Care Center

Provider #: 0003038

08/01/2004 to 07/31/2005

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Disallow lab and x-ray fees	(17,189)	43
Disallow board of director expense	(1,643)	43
Disallow out of state travel	(530)	24
Disallow prepaid travel and seminar	(345)	24
Disallow collection fees	(6,284)	19
To reclass capitalized repairs and maintenanc	(65,294)	6
Offset vending machine income	(11,381)	43
Offset miscellaneous income	<u>260</u>	21
Total	<u><u>(102,406)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Elmhurst Extended Care Center

ID# 0003038

Report Period Beginning: 08/01/2004

Ending: 07/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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24			24
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27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

07/31/2005

[illegible][illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Elmhurst Extended Care Center# 0003038Report Period Beginning: 08/01/2004 Ending: 07/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John Massard	100%	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V				N/A				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Elmhurst Extended Care Center # 0003038 Report Period Beginning: 08/01/2004 Ending: 07/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Massard	President/Owner	Administrator	100.00	None	40	100.00	Salary	\$ 88,578	L17, C1	1
2	Peggy Massard	Secretary/Bookkeeper	Secretary/Bookkeeper	0.00	None	40	100.00	Salary	44,404	L21, C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 132,982		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center# 0003038

Report Period Beginning:

08/01/2004Ending: 7/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5			N/A						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Itasca Bank & Trust Company		X	Mortgage	\$11,039.89	6/14/04	\$ 1,700,000	\$ 1,666,832	6/14/2029	0.0600	\$ 107,243	1	
2	Sidney & Bonnie Gibbons	X		Purchase of Company Stock		6/14/04	300,000		7/14/09	0.0400		2	
3								Amortization of mortgage costs			3,287	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$11,039.89		\$ 2,000,000	\$ 1,666,832			\$ 110,530	9	
	B. Non-Facility Related*												
10												10	
11								Insurance premium financing			1,989	11	
12												12	
13								Interest income offset			(5,321)	13	
14	TOTAL Non-Facility Related						\$	\$			(3,332)	14	
15	TOTALS (line 9+line14)						\$ 2,000,000	\$ 1,666,832			\$ 107,198	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Elmhurst Extended Care Center**# **0003038** Report Period Beginning: **08/01/2004** Ending: **07/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report	\$	38,941	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2004	\$	36,289	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,652)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			\$		6
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	33,848	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	34,376	8	
		2001	35,645	9	
		2002	37,798	10	
		2003	35,003	11	
		2004	36,289	12	
Accrual at 8/01/04 (\$38,941)					
Real estate taxes paid \$36,289					
Real estate taxes expense \$33,848					
Accrual at 7/31/05 (\$36,500) (Same as 2004 taxes paid)					

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmhurst Extended Care Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0003038

CONTACT PERSON REGARDING THIS REPORT John Massard

TELEPHONE (630) 834-4337 FAX #: (630) 834-4122

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>03-36-309-029</u>	<u>Nursing Home</u>	\$ <u>36,288.94</u>	\$ <u>36,288.94</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>36,288.94</u>	\$ <u>36,288.94</u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center

0003038 Report Period Beginning:

08/01/2004 Ending:

07/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,019 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☐ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient care	41,851	1961	\$ 92,016	1
2	Parking lot			6,950	2
3	TOTALS			\$ 98,966	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center

0003038

Report Period Beginning:

08/01/2004 Ending: 07/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	39		1961	1961	\$ 122,779	\$	40	\$		\$ 122,779	4
5	73		1976	1976	1,174,345	18,386	40	18,878	492	964,909	5
6			1980	1980	46,390	1,056	40	1,160	104	30,217	6
7			1998	1998	700	36	10	70	34	490	7
8			1998	1998	43,075	2,872	15	2,872		18,666	8
	Improvement Type**										
9	Other		1983		7,336		12			7,336	9
10	Other		1984		5,800		15			5,800	10
11	Other		1987		1,630		10			1,630	11
12	Other		1989		7,744		10			7,744	12
13	Front walk		1995		4,900	281	10	408	127	4,900	13
14	Ceiling tile		1996		4,960	279	20	248	(31)	2,288	14
15	New sign		1997		11,049	2,258	10	1,105	(1,153)	9,330	15
16	Retaining wall		1998		6,800	303	10	680	377	4,805	16
17	Fire dampers		1999		6,169	496	10	617	121	4,010	17
18	Rewiring		1999		4,356	350	10	436	86	2,832	18
19	Tile		1999		2,945	204	20	147	(57)	957	19
20	Wood fence		2000		1,349	144	10	135	(9)	742	20
21	Parking lot		2000		1,000	103	10	100	(3)	550	21
22	Hand rail		2001		1,813	162	10	181	19	816	22
23	Rail		2001		2,527	226	10	253	27	1,137	23
24	Kitchen air unit		2002		17,790	2,258	20	890	(1,368)	3,026	24
25	Gates and railing		2002		2,500	256	20	125	(131)	425	25
26	Laundry exhaust ductwork		2003		1,980	243	10	198	(45)	495	26
27	Basement corridor flooring		2004		3,335	275	20	167	(108)	250	27
28	Tile and cover base		2004		926	76	20	46	(30)	69	28
29	Tile and cover base		2004		2,248	219	20	112	(107)	168	29
30	Outside improvements		2004		91,411		20	4,571	4,571	6,856	30
31	Breaker and amp		2005		5,930	445	10	247	(198)	247	31
32	Wallpaper, flooring, painting		2004		44,630	986	10	3,383	2,397	3,383	32
33	Locking system		2005		10,357	1,109	10	471	(638)	471	33
34	Counter top		2005		2,899	181	10	169	(12)	169	34
35	Call light system		2005		33,993	2,774	10	830	(1,944)	830	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Carpet	2005	\$ 3,913	\$ 140	10	\$ 65	\$ (75)	\$ 65	37
38	Flooring	2005	22,881	630	20	118	(512)	118	38
39	Alarm system	2005	1,013		10	42	42	42	39
40	Elevator pipe replaced	2005	2,135		10	71	71	71	40
41	Hand rails and bumper guard	2004	6,666		10	444	444	444	41
42	Ceiling light fixtures	2004	2,347		10	156	156	156	42
43	Privacy curtain	2005	968		10	32	32	32	43
44	Signs	2005	1,697		10	57	57	57	44
45	Ceiling tile	2004	4,117		20	137	137	137	45
46	Door locking system	2005	1,125		10	56	56	56	46
47	Exhaust fan	2005	835		10	14	14	14	47
48	Thermostat guard	2004	582		10	44	44	44	48
49	Pump in boiler room	2005	1,704		10	85	85	85	49
50	Replace electrical boxes	2005	2,576		20	21	21	21	50
51	Nurses station counter top	2005	1,293		10	22	22	22	51
52	Replace pipes	2005	5,912		10	197	197	197	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,735,430	\$ 36,748		\$ 40,060	\$ 3,312	\$ 1,209,888	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number: Elmhurst Extended Care Center

0003038

Report Period Beginning:

08/01/2004

Ending:

07/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component/ Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 978,283	\$ 35,697	\$ 75,183	\$ 39,486	10-20 yrs	\$ 598,971	71
72	Current Year Purchases	32,964	4,549	1,330	(3,219)	5-10 yrs	1,330	72
73	Fully Depreciated Assets	201,212				10 yrs	201,212	73
74								74
75	TOTALS	\$ 1,212,459	\$ 40,246	\$ 76,513	\$ 36,267		\$ 801,513	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient care	Mini bus	1995	\$ 44,094	\$	\$	\$	3	\$ 44,094	76
77										77
78										78
79										79
80	TOTALS			\$ 44,094	\$	\$	\$		\$ 44,094	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,090,949	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 76,994	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,573	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,579	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,055,495	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2003 Dodge Ram	\$ 44,099	\$ 8,820	\$ 38,101	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 44,099	\$ 8,820	\$ 38,101	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column f

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ **N/A** Description:

(Attach a schedule detailing the breakdown of movable equipment)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

Facility Name & ID Number Elmhurst Extended Care Center # 0003038 Report Period Beginning: 08/01/2004 Ending: 07/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities:

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	L10A, C1, 2 & 3	2153	hrs	\$ 66,243	291	\$ 12,207	\$ 359	2,444	\$ 78,809	1
2	Licensed Speech and Language Development Therapist	L10A, C3		hrs		261	13,060		261	13,060	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10A, C1, 2 & 3	4416	hrs	123,018	532	27,666	34	4,948	150,718	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L39, C2		# of prescripts				206,432		206,432	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				\$ 189,261	1,084	\$ 52,933	\$ 206,825	7,653	\$ 449,019	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Elmhurst Extended Care Center

Provider #: 0003038

08/01/2004 to 07/31/2005

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	---------------------------	-------------------------------------	-------------	-----------------

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits	581,397	581,397	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 5,000)	262,180	262,180	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,706	110,706	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 954,283	\$ 954,283	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,966	98,966	13
14	Buildings, at Historical Cost	1,610,579	1,597,895	14
15	Leasehold Improvements, at Historical Cost	137,535	137,535	15
16	Equipment, at Historical Cost	1,149,577	1,256,553	16
17	Accumulated Depreciation (book methods)	(2,425,365)	(2,055,495)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Non-care fixed asset)		5,998	22
23	Other(specify): See attached Schedule 17A	26,065	26,065	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 597,357	\$ 1,067,517	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,551,640	\$ 2,021,800	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 76,727	\$ 76,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	33,430	33,430	29
30	Accrued Salaries Payable	274,320	274,320	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,500	36,500	32
33	Accrued Interest Payable	4,000	4,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	117,159	117,159	35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	80,978	80,978	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 623,114	\$ 623,114	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,633,402	1,633,402	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,633,402	\$ 1,633,402	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,256,516	\$ 2,256,516	46
47	TOTAL EQUITY (page 18, line 24)	\$ (704,876)	\$ (234,716)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,551,640	\$ 2,021,800	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Elmhurst Extended Care Center
Provider #: 0003038
08/01/2004 to 07/31/2005

Schedule 17A

XV. Balance Sheet
Line 23: Other Assets

	Operating	After Consolidation
Mortgage fees	12,434	12,434
Deposits	<u>13,631</u>	<u>13,631</u>
	<u>26,065</u>	<u>26,065</u>

Line 36: Other Current Liabilities

401 (k) pension	14,325	14,325
Accrued IPAC tax	5,208	5,208
Accrued insurance	50,595	50,595
Accrued expense payable	<u>10,850</u>	<u>10,850</u>
	<u>80,978</u>	<u>80,978</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,254,645)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,254,645)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	549,769	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 549,769	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (704,876)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Elmhurst Extended Care Center

0003038

Report Period Beginning: 08/01/2004

Ending: 07/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,660,596	1
2	Discounts and Allowances for all Levels	(1,020,828)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,639,768	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	513,661	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 513,661	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,159	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	207,386	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	11,302	19
20	Radiology and X-Ray	7,647	20
21	Other Medical Services	414,082	21
22	Laundry	6,450	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 664,026	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	5,321	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,321	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending machine income	13,873	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,873	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,836,649	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	906,713	31
32	Health Care	2,447,258	32
33	General Administration	904,140	33
B. Capital Expense			
34	Ownership	229,288	34
C. Ancillary Expense			
35	Special Cost Centers	386,661	35
36	Provider Participation Fee	61,320	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,935,380	40
41	Income before Income Taxes (line 30 minus line 40)**	901,269	41
42	Income Taxes	351,500	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 549,769	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Elmhurst Extended Care Center# 0003038Report Period Beginning: 08/01/2004Ending: 07/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,160	2,160	\$ 87,252	\$ 40.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,313	14,313	404,088	28.23	3
4	Licensed Practical Nurses	16,381	16,381	396,944	24.23	4
5	CNAs & Orderlies	65,300	65,300	798,850	12.23	5
6	CNA Trainees					6
7	Licensed Therapist	6,536	6,536	189,261	28.96	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,120	2,120	36,060	17.01	9
10	Activity Assistants	3,349	3,349	33,287	9.94	10
11	Social Service Worker	2,080	2,080	42,744	20.55	11
12	Dietician	2,080	2,080	46,220	22.22	12
13	Food Service Supervisor					13
14	Head Cook	2,276	2,276	39,617	17.41	14
15	Cook Helpers/Assistants	9,386	9,386	103,444	11.02	15
16	Dishwashers	3,880	3,880	30,812	7.94	16
17	Maintenance Worker	2,866	2,866	41,710	14.55	17
18	Housekeepers	15,701	15,701	169,135	10.77	18
19	Laundry	3,000	3,000	23,999	8.00	19
20	Administrator	2,080	2,080	88,578	42.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,120	2,120	44,970	21.21	23
24	Clerical	6,240	6,240	191,719	30.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,064	2,064	35,668	17.28	31
32	Other Health C: <u>See attached Sch. 2</u>	4,160	4,160	120,490	28.96	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	168,092	168,092	\$ 2,924,848 *	\$ 17.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	150	30,000	L9, C3	36
37	Medical Records Consultant	66	1,458	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	442	L11, C3	44
45	Social Service Consultant	12	1,142	L12, C3	45
46	Other(specify) <u>Dentist</u>	24	600	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	261	\$ 33,642		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	39	\$ 1,951	L10, C3	50
51	Licensed Practical Nurses	759	29,683	L10, C3	51
52	Certified Nurse Assistants/Aides	856	15,748	L10, C3	52
53	TOTAL (lines 50 - 52)	1,654	\$ 47,382		53

SEE ACCOUNTANTS' COMPILATION REPORT

Elmhurst Extended Care Center

Provider #: 0003038

08/01/2004 to 07/31/2005

Schedule 20A

Schedule XVIII

Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	2,080	2,080	56,090	26.97
Restorative Nurse	2,080	2,080	64,400	30.96
Total	4,160	4,160	120,490	

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
John Massard	Administrator	100%	\$ 88,578	Workers' Compensation Insurance		\$ 42,534	IDPH License Fee		\$ 1,990		
				Unemployment Compensation Insurance		38,582	Advertising: Employee Recruitment		7,697		
				FICA Taxes		205,504	Health Care Worker Background Check (Indicate # of checks performed 82)		656		
				Employee Health Insurance		67,621	Illinois Health Care Association		5,873		
				Employee Meals			HCPRO		474		
				Illinois Municipal Retirement Fund (IMRF)*			Illinois Podiatric Medical Association		1,472		
				401(k) Match		14,000	Miscellaneous dues and subscriptions		700		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,578	Employee Relations		7,424	Miscellaneous licenses and fees		960		
B. Administrative - Other											
Description			Amount				Less: Public Relations Expense		()		
			\$				Non-allowable advertising		()		
							Yellow page advertising		()		
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,822		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 376,478					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**d			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
Sigel, Albin, Landau & Rubin	Collections		\$ 6,284			\$	Out-of-State Travel	\$			
Duane Morris	Legal		780								
Slupik and Associates, Ltd.	Accounting		11,140								
Benefit Planning Consultants, Inc.	Benefit Plan Consulting		1,920	N/A			In-State Travel	370			
Talx	U/C Services		150								
Sheakly Uniservice	U/C Services		400								
Nursing Resources International	Employment Agency		3,315								
Accu-Med Services, Inc.	Computer Consulting		4,785				Seminar Expense	12,807			
Care Computer Systems	Computer Consulting		1,720								
Keane Care, Inc.	Computer Consulting		1,973								
See attached Schedule 21A			4,193								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 36,660	TOTAL		\$	Entertainment Expense	()			
							(agree to Sch. V, line 24, col. 8)	\$ 13,177			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Elmhurst Extended Care Center

Provider #: 0003038

08/01/2004 to 07/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Hands on Technology, Inc.	Computer Consulting	2,120
Best Software	Computer Consulting	2,073
		<hr/>
		4,193
		<hr/>
Total (agree to Schedule V, line 19, column 3)		<hr/>
		36,660
		<hr/>
Nonallowable Legal Fees		
Sigel, Albin, Landau, & Rubin	Collections	(6,284)
		<hr/>
Total (agree to Schedule V, line 19, column 8)		<hr/>
		30,376
		<hr/>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmhurst Extended Care Center

0003038

Report Period Beginning: 08/01/2004

Ending: 07/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report Yes
If YES, give association name and amount Illinois Health Care Association - \$5,873
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases Yes
What was the average life used for new equipment added during this period 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 38,063 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,320
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these function
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? No Indicate the amount \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel No
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT

03:33 PM 3/20/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-217,671	equal to	-217,671	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	107,198	equal to	107,198	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	33,848	equal to	33,848	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	116,573	equal to	116,573	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	189,261	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	242,587	equal to	242,587	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	206,825	equal to	206,825	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	906,713	equal to	906,713	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,447,258	equal to	2,447,258	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	904,140	equal to	904,140	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	229,288	equal to	229,288	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	386,661	equal to	386,661	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	61,320	equal to	61,320	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,722,802	equal to	1,843,292	-120,490	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	189,261	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	69,347	equal to	69,347	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	42,744	equal to	42,744	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	220,093	equal to	220,093	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	41,710	equal to	41,710	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	169,135	equal to	169,135	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	23,999	equal to	23,999	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	88,578	equal to	88,578	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	236,689	equal to	236,689	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,924,848	equal to	2,924,848	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	30,000	< or = to	30,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	48,840	< or = to	51,787	-2,947	FAILED	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	442	< or = to	442	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,142	< or = to	1,142	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	88,578	equal to	88,578	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	36,660	equal to	36,660	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	376,478	equal to	376,478	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	19,822	equal to	19,822	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	13,177	equal to	13,177	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particp. Fees	61,320	equal to	61,320	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	7,088	equal to	7,471	-383	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	1,666,832	equal to	1,666,832	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	36,500	equal to	36,500	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	98,966	equal to	98,966	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,735,430	equal to	1,735,430	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,256,553	equal to	1,256,553	0	O.K.	Pg13 O22+L13	C & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,055,495	equal to	2,055,495	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-704,876	equal to	-704,876	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	549,769	equal to	549,769	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,551,640	equal to	1,551,640	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1

Elmhurst Extended Care Center
IDPA Comparative Data - Per Resident Day Cost
Year Ending 07/31/2005

Enter your HSA # in next column
Census (Pulls from Page 2)

1
29,935

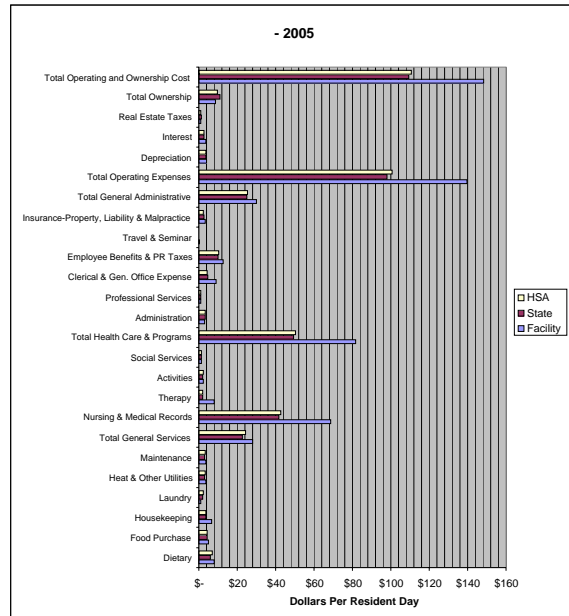
Cost Report Line	Description	Average Median Cost Per Day			IDPA LTC Profiles	UN-INFLATED	State- Wide	HSA											10th %	90th %	
		Your Facility	State	HSA				1	2	3	4	5	6	7	8	9	10	11			
1	Dietary	8.17	6.10	7.02	LTC Median Per Diem Cost by HSA - 2003 Cost Reports			7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81	
2	Food Purchase	5.04	4.31	4.47	2003 (Run June 1, 2004)			4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04	
3	Housekeeping	6.57	3.70	3.59				3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80	
4	Laundry	0.90	1.85	2.23				2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14	
5	Heat & Other Utilities	3.65	2.95	3.17				2.93	2.93	2.94	2.93	2.71	2.93	2.93	2.91	3.17	2.95	2.05	4.25	2.05	
6	Maintenance	3.56	3.01	3.26				3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	Total General Services	27.89	22.58	24.49	1 Dietary		6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81	
10	Nursing & Medical Records	68.80	41.83	42.52	2 Food Purchase		4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04	
10A	Therapy	8.10	2.10	1.86	3 Housekeeping		3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80	
11	Activities	2.39	1.91	2.18	4 Laundry		1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14	
12	Social Services	1.47	1.42	1.45	5 Heat & Other Utilities		2.95	2.93	2.93	2.94	2.93	2.71	2.93	2.93	2.91	3.17	2.95	2.05	4.25	2.05	
16	Total Health Care & Programs	81.75	49.48	50.39	6 Maintenance		3.26	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
17	Administration	2.96	3.36	3.33	8 TOTAL GENERAL SERVICES		22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51	
19	Professional Services	1.01	0.99	1.09	10 Nursing & Medical Records		41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47	
21	Clerical & Gen. Office Expense	8.87	4.79	4.32	10A Therapy		2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55	
22	Employee Benefits & PR Taxes	12.58	10.09	10.42	11 Activities		1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45	
24	Travel & Seminar	0.44	0.08	0.10	12 Social Services		1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00	
26	Insurance-Property, Liability & Malpractice	3.26	2.58	2.47	16 TOTAL HEALTH CARE & PROGRAMS		3.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23	
28	Total General Administrative	29.97	24.94	25.31	17 Administration		3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21	
29	Total Operating Expenses	139.62	98.06	100.77	19 Professional Services		0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44	
30	Depreciation	3.89	3.70	3.82	21 Clerical & Gen. Office Expense		4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78	
32	Interest	3.58	2.54	2.81	22 Employee Benefits & PR Taxes		10.42	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34	
33	Real Estate Taxes	1.13	1.38	0.92	24 Travel & Seminar		0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43	
37	Total Ownership	8.61	11.11	9.73	26 Insurance-Property, liability & Malpractice		2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32	
	Total Operating and Ownership Cost	148.22	110.50	111.50	28 TOTAL GENERAL ADMINISTRATIVE		24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14	
					29 TOTAL OPERATING EXPENSES		98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56	
					30 Depreciation		3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43	
					32 Interest		2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53	
					33 Real Estate Taxes		1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85	
					37 TOTAL OWNERSHIP		11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	3.76	23.58	
					TOTAL OPERATING & OWNERSHIP CC		109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14	

Notes:

Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.

Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.
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IDPA Comparative Data - Per Resident Day Cost
Year Ending

Enter your HSA # in next column
Census (Pulls from Page 2)

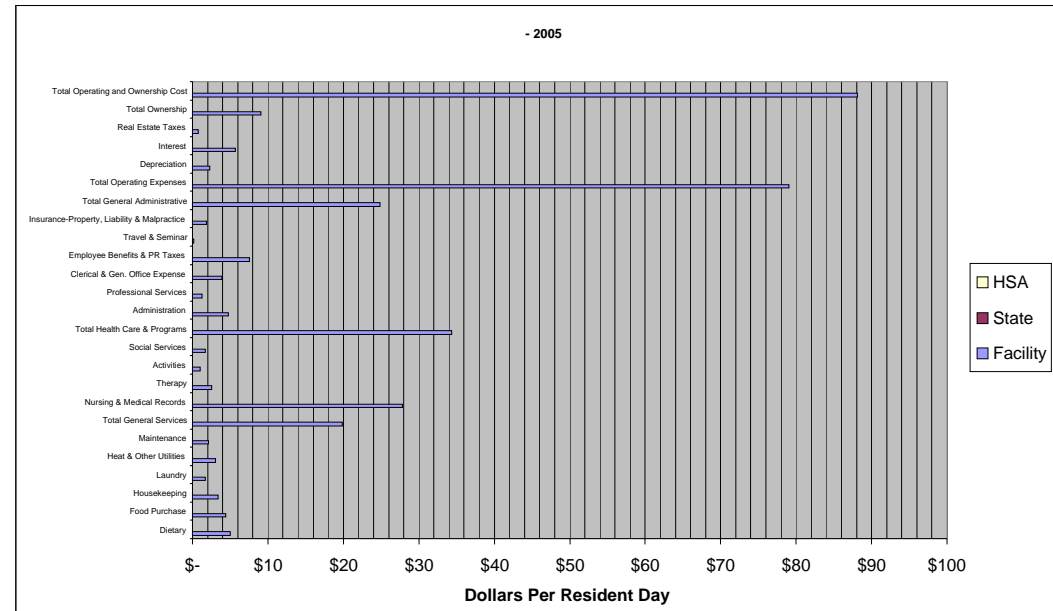
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29,935

Cost Report Line	Description	2005	2004 Median		2004	2004 Median		2003	2003 Median		2002	2002 Median	
		Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA
1	Dietary	5.04	-	-	#DIV/0!	-	-	#DIV/0!	6.01	7.28	#DIV/0!	6.01	7.28
2	Food Purchase	4.43	-	-	#DIV/0!	-	-	#DIV/0!	4.27	4.52	#DIV/0!	4.27	4.52
3	Housekeeping	3.38	-	-	#DIV/0!	-	-	#DIV/0!	3.65	3.84	#DIV/0!	3.65	3.84
4	Laundry	1.71	-	-	#DIV/0!	-	-	#DIV/0!	1.90	2.15	#DIV/0!	1.90	2.15
5	Heat & Other Utilities	3.04	-	-	#DIV/0!	-	-	#DIV/0!	2.71	2.84	#DIV/0!	2.71	2.84
6	Maintenance	2.16	-	-	#DIV/0!	-	-	#DIV/0!	2.99	3.41	#DIV/0!	2.99	3.41
8	Total General Services	19.81	-	-	#DIV/0!	-	-	#DIV/0!	22.09	24.39	#DIV/0!	22.09	24.39
10	Nursing & Medical Records	27.84	-	-	#DIV/0!	-	-	#DIV/0!	40.68	42.79	#DIV/0!	40.68	42.79
10A	Therapy	2.57	-	-	#DIV/0!	-	-	#DIV/0!	1.85	1.90	#DIV/0!	1.85	1.90
11	Activities	1.02	-	-	#DIV/0!	-	-	#DIV/0!	1.88	2.12	#DIV/0!	1.88	2.12
12	Social Services	1.72	-	-	#DIV/0!	-	-	#DIV/0!	1.44	1.46	#DIV/0!	1.44	1.46
16	Total Health Care & Programs	34.37	-	-	#DIV/0!	-	-	#DIV/0!	47.55	50.19	#DIV/0!	47.55	50.19
17	Administration	4.73	-	-	#DIV/0!	-	-	#DIV/0!	3.39	3.49	#DIV/0!	3.39	3.49
19	Professional Services	1.24	-	-	#DIV/0!	-	-	#DIV/0!	0.98	1.00	#DIV/0!	0.98	1.00
21	Clerical & Gen. Office Expense	3.88	-	-	#DIV/0!	-	-	#DIV/0!	4.58	4.07	#DIV/0!	4.58	4.07
22	Employee Benefits & PR Taxes	7.54	-	-	#DIV/0!	-	-	#DIV/0!	9.63	10.11	#DIV/0!	9.63	10.11
24	Travel & Seminar	0.15	-	-	#DIV/0!	-	-	#DIV/0!	0.09	0.12	#DIV/0!	0.09	0.12
26	Insurance-Property, Liability & Malpractice	1.87	-	-	#DIV/0!	-	-	#DIV/0!	2.19	1.93	#DIV/0!	2.19	1.93
28	Total General Administrative	24.89	-	-	#DIV/0!	-	-	#DIV/0!	23.47	23.64	#DIV/0!	23.47	23.64
29	Total Operating Expenses	79.07	-	-	#DIV/0!	-	-	#DIV/0!	94.39	99.26	#DIV/0!	94.39	99.26
30	Depreciation	2.31	-	-	#DIV/0!	-	-	#DIV/0!	3.53	3.13	#DIV/0!	3.53	3.13
32	Interest	5.67	-	-	#DIV/0!	-	-	#DIV/0!	2.73	2.84	#DIV/0!	2.73	2.84
33	Real Estate Taxes	0.80	-	-	#DIV/0!	-	-	#DIV/0!	1.30	0.77	#DIV/0!	1.30	0.77
37	Total Ownership	9.08	-	-	#DIV/0!	-	-	#DIV/0!	11.44	9.19	#DIV/0!	11.44	9.19
	Total Operating and Ownership Cost	88.15	-	-	#DIV/0!	-	-	#DIV/0!	108.45	108.45	#DIV/0!	105.83	108.45

Notes:

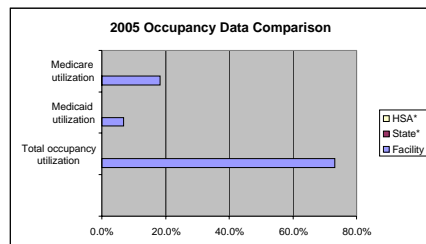
Your Facility data is from page 3, column 8 of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2001 & 2002 Median Cost Per Day, for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.



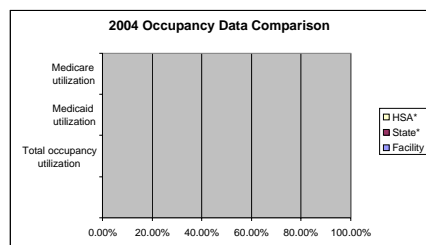
2005

Your			
Facility	State*	HSA*	
Total occupancy utilization	73.23%	0.00%	0.00%
Medicaid utilization	6.88%	0.00%	0.00%
Medicare utilization	18.28%	0.00%	0.00%
Private pay percent utilization	48.07%	N/A	N/A
Capacity in Patient Days	40,880	N/A	N/A
Census days of service provided	29,935	N/A	N/A



2004

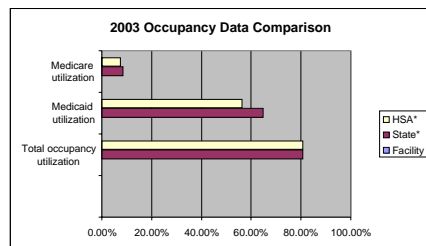
Your			
Facility	State*	HSA*	
Total occupancy utilization	#DIV/0!	0.00%	0.00%
Medicaid utilization		0.00%	0.00%
Medicare utilization		0.00%	0.00%
Private pay percent utilization	N/A	N/A	
Capacity in Patient Days	N/A	N/A	
Census days of service provided	N/A	N/A	



* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

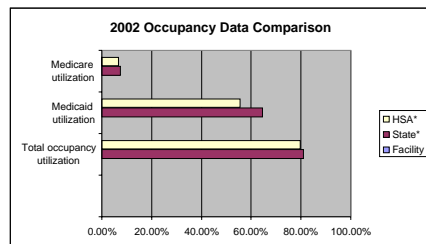
2003

Your			
Facility	State*	HSA*	
Total occupancy utilization	#DIV/0!	80.80%	80.80%
Medicaid utilization		64.80%	56.40%
Medicare utilization		8.50%	7.50%
Private pay percent utilization	N/A	N/A	
Capacity in Patient Days	N/A	N/A	
Census days of service provided	N/A	N/A	

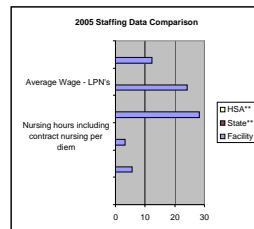


2002

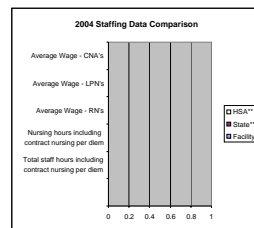
Your			
Facility	State*	HSA*	
Total occupancy utilization	#DIV/0!	80.90%	79.60%
Medicaid utilization		64.50%	55.50%
Medicare utilization		7.40%	6.80%
Private pay percent utilization	N/A	N/A	
Capacity in Patient Days	N/A	N/A	
Census days of service provided	N/A	N/A	



2005			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	5.67	0.00	0.00
Nursing hours including contract nursing per diem	3.33	0.00	0.00
Average Wage - RN's	28.23	0.00	0.00
Average Wage - LPN's	24.23	0.00	0.00
Average Wage - CNA's	12.23	0.00	0.00

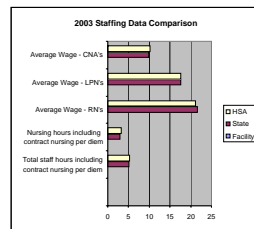


2004			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	0.00	0.00	
Nursing hours including contract nursing per diem	0.00	0.00	
Average Wage - RN's	0.00	0.00	
Average Wage - LPN's	0.00	0.00	
Average Wage - CNA's	0.00	0.00	

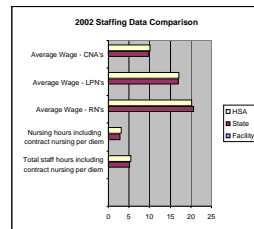


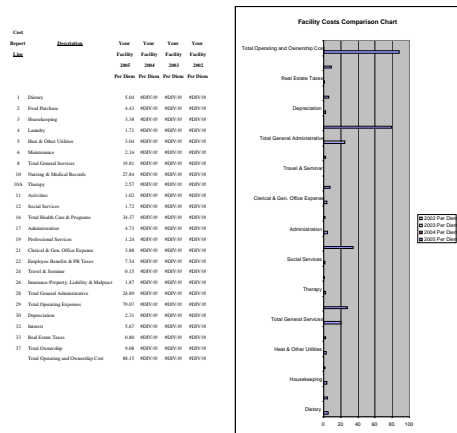
** State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

2003			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.10	5.30	
Nursing hours including contract nursing per diem	2.90	3.20	
Average Wage - RN's	21.56	21.14	
Average Wage - LPN's	17.64	17.65	
Average Wage - CNA's	9.91	10.11	

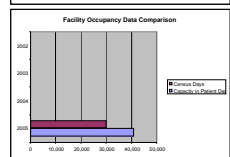
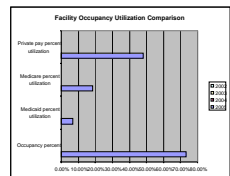


2002			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.20	5.50	
Nursing hours including contract nursing per diem	2.80	3.10	
Average Wage - RN's	20.69	20.12	
Average Wage - LPN's	16.89	17.04	
Average Wage - CNA's	9.73	10.05	

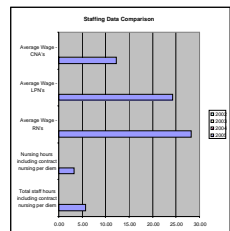




	Facility	Facility	Facility	Facility
	2003	2004	2005	2006
Occupancy percent	75.00%	4500.00	4500.00	4500.00
Medicare percent utilization	0.00%	0.00%	0.00%	0.00%
Medicaid percent utilization	0.00%	0.00%	0.00%	0.00%
Private pay percent utilization	0.00%	0.00%	0.00%	0.00%
Capacity in Patient Days	40,000	0	0	0
Census Days	30,000	0	0	0



	Facility	Facility	Facility	Facility
	2003	2004	2005	2006
Total staff hours including contract nursing per day	0.00	0.00	0.00	0.00
Nursing hours including contract nursing per day	0.00	0.00	0.00	0.00
Average Wage- RNs	0.00	0.00	0.00	0.00
Average Wage- LPNs	0.00	0.00	0.00	0.00
Average Wage- CNAs	0.00	0.00	0.00	0.00



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	220,093	24,374	0	244,467	0	244,467	0	244,467
2. Food Purchase	0	150,888	0	150,888	0	150,888	0	150,888
3. Housekeeping	169,135	27,517	0	196,652	0	196,652	0	196,652
4. Laundry	23,999	9,375	0	33,374	0	33,374	(6,450)	26,924
5. Heat and Other Utilities	0	0	109,409	109,409	0	109,409	0	109,409
6. Maintenance	41,710	0	130,213	171,923	0	171,923	(65,294)	106,629
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	454,937	212,154	239,622	906,713	0	906,713	(71,744)	834,969
9. Medical Director	0	0	30,000	30,000	0	30,000	0	30,000
10. Nursing & Medical Records	1,843,292	164,303	51,787	2,059,382	0	2,059,382	0	2,059,382
10a. Therapy	189,261	393	52,933	242,587	0	242,587	0	242,587
11. Activities	69,347	1,614	442	71,403	0	71,403	0	71,403
12. Social Services	42,744	0	1,142	43,886	0	43,886	0	43,886
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,144,644	166,310	136,304	2,447,258	0	2,447,258	0	2,447,258
17. Administrative	88,578	0	0	88,578	0	88,578	0	88,578
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	36,660	36,660	0	36,660	(6,284)	30,376
20. Fees, Subscriptions & Promotion	0	0	19,822	19,822	0	19,822	0	19,822
21. Clerical & General Office	236,689	17,274	11,392	265,355	0	265,355	260	265,615
22. Employee Benefits & Payroll	0	0	376,478	376,478	0	376,478	0	376,478
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	14,052	14,052	0	14,052	(875)	13,177
25. Other Admin. Staff Trans	0	0	5,691	5,691	0	5,691	0	5,691
26. Insurance-Prop.Liab.Malpractice	0	0	97,504	97,504	0	97,504	0	97,504
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	325,267	17,274	561,599	904,140	0	904,140	(6,899)	897,241
29. Total General Administrative	2,924,848	395,738	937,525	4,258,111	0	4,258,111	(78,643)	4,179,468
30. Depreciation	0	0	82,921	82,921	0	82,921	33,652	116,573
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	112,519	112,519	0	112,519	(5,321)	107,198
33. Real Estate	0	0	33,848	33,848	0	33,848	0	33,848
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	229,288	229,288	0	229,288	28,331	257,619
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	206,432	0	206,432	0	206,432	0	206,432
40. Barber and Beauty Shop	0	0	12,870	12,870	0	12,870	0	12,870
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	61,320	61,320	0	61,320	0	61,320
43. Other (specify):*	0	0	167,359	518,859	0	518,859	(167,359)	351,500
44. Total Special Cost Ce	0	206,432	593,049	799,481	0	799,481	(167,359)	632,122
45. Grand Total	2,924,848	602,170	1,759,862	5,286,880	0	5,286,880	(217,671)	5,069,209

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	581,397	581,397
3. Accounts & Notes Receivable	262,180	262,180
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	110,706	110,706
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	954,283	954,283
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	98,966	98,966
14. Buildings, at Historical Cost	1,610,579	1,597,895
15. Leasehold Improvements, Historical Cost	137,535	137,535
16. Equipment, at Historical Cost	1,149,577	1,256,553
17. Accumulated Depreciation (book methods)	#####	-2,055,495
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	5,998
23. other (specify):	26,065	26,065
24. Total Long-Term Assets	597,357	1,067,517
25. Total Assets	1,551,640	2,021,800
CURRENT LIABILITIES		
26. Accounts Payable	76,727	76,727
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	33,430	33,430
30. Accrued Salaries Payable	274,320	274,320
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	36,500	36,500
33. Accrued Interest Payable	4,000	4,000
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	117,159	117,159
36. Other Current Liabilities (specify):	80,978	80,978
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	623,114	623,114
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	1,633,402	1,633,402
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	1,633,402	1,633,402
46. Total Liabilities	2,256,516	2,256,516
47. Total Equity	-704,876	-234,716
48. Total Liabilities and Equity	1,551,640	2,021,800

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,660,596
2. Discounts and Allowances for all Levels	-1,020,828
Subtotal - Inpatient Care	4,639,768
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	513,661
7. Oxygen	0
Subtotal - Ancillary Revenue	513,661
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	17,159
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	207,386
18. Sale of Supplies to Non-Patients	0
19. Laboratory	11,302
20. Radiology and X-Ray	7,647
21. Other Medical Services	414,082
22. Laundry	6,450
Subtotal - Other Operating Revenue	664,026
24. Contributions	0
25. Interest and Other Investments Income	5,321
Subtotal - Non-Operating Revenue	5,321
27. Other Revenue (specify):	0
28. Other Revenue (specify):	13,873
Subtotal - Other Revenue	13,873
30. Total Revenue	5,836,649
31. General Services	906,713
32. Health Care	2,447,258
33. General Administration	904,140
34. Ownership	229,288
35. Special Cost Centers	738,161
35. Provider Participation Fee	61,320
37. Other	0
40. Total Expenses	5,286,880
41. Income Before Income Taxes	549,769
42. Income Taxes	0
43. Net Income or Loss for the Year	549,769

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LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2005 (Run June 1, 2004)

UN-INFLATED

[illegible]

2005 - Average Wage Data Table

[illegible]

2005 - Staffing and Occupancy Data

[illegible]

2004 Costs

2004
Census

Cost Report	
<u>Line</u>	<u>Description</u>
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
32	Depreciation
33	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2004 (Run June 1, 2004)

UN-INFLATED

[illegible]

2004		2004
Costs		Census
Cost		
Report		
<u>Line</u>	<u>Description</u>	
1	Dietary	
2	Food Purchase	
3	Housekeeping	
4	Laundry	
5	Heat & Other Utilities	
6	Maintenance	
8	TOTAL GENERAL SERVICES	
10	Nursing & Medical Records	
10A	Therapy	
11	Activities	
12	Social Services	
16	TOTAL HEALTH CARE & PROGRAMS	
17	Administration	
19	Professional Services	
21	Clerical & Gen. Office Expense	
22	Employee Benefits & PR Taxes	
24	Travel & Seminar	
26	Insurance-Property, liability & Malpractice	
28	TOTAL GENERAL ADMINISTRATIVE	
29	TOTAL OPERATING EXPENSES	
30	Depreciation	
32	Interest	
33	Real Estate Taxes	
37	TOTAL OWNERSHIP	
	TOTAL OPERATING & OWNERSHIP COST	

2004 - Average Wage Data Table

[illegible]

2004 - Staffing and Occupancy Data

[illegible]

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Cost Report		State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
<u>Line</u>	<u>Description</u>		1	2	3	4	5	6	7	8	9	10	11	
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.06	0.06	0.06	0.06	0.05	0.10	0.07	
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	
	TOTAL OPERATING & OWNERSHIP COST	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	

10th %	90th %
4.13	9.81
3.36	6.04
2.48	5.80
0.91	3.14
2.05	4.25
1.92	5.12
17.57	31.51
27.25	64.47
-	10.55
1.06	3.45
0.58	3.00
32.10	77.23
1.71	7.21
0.07	3.44
2.49	10.78
6.33	19.34
-	0.43
0.88	4.32
16.95	39.14
69.40	142.56
1.01	8.43
-	11.53
-	4.85
3.76	23.58
73.16	166.14

2003 Costs

2003
Census

Cost Report		<u>Line</u>	<u>Description</u>
1	Dietary	1	
2	Food Purchase	2	
3	Housekeeping	3	
4	Laundry	4	
5	Heat & Other Utilities	5	
6	Maintenance	6	
8	TOTAL GENERAL SERVICES	8	
10	Nursing & Medical Records	10	
10A	Therapy	10A	
11	Activities	11	
12	Social Services	12	
16	TOTAL HEALTH CARE & PROGRAMS	16	
17	Administration	17	
19	Professional Services	19	
21	Clerical & Gen. Office Expense	21	
22	Employee Benefits & PR Taxes	22	
24	Travel & Seminar	24	
26	Insurance-Property, liability & Malpractice	26	
28	TOTAL GENERAL ADMINISTRATIVE	28	
29	TOTAL OPERATING EXPENSES	29	
30	Depreciation	30	
32	Interest	32	
33	Real Estate Taxes	33	
37	TOTAL OWNERSHIP	37	
	TOTAL OPERATING & OWNERSHIP COST		

2003 - Average Wage Data Table

	State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
		1	2	3	4	5	6	7	8	9	10
Total staff hours including contract nurses per diem	5.10	5.30	5.30	5.00	5.30	5.10	4.90	4.90	4.90	5.10	5.30
Nursing hours including contract nurses per diem	2.90	3.20	3.10	3.10	3.10	3.00	2.70	2.70	2.70	3.00	3.10
RN	21.56	21.14	19.99	18.79	19.99	16.66	24.55	24.55	24.55	22.85	21.14
LPN	17.64	17.65	16.41	14.79	16.41	13.36	20.23	20.23	20.23	18.67	17.65
CNA	9.91	10.11	9.89	9.19	9.89	8.28	10.44	10.44	10.44	10.54	10.11
DON	27.82	26.67	24.49	23.07	24.49	20.82	33.29	33.29	33.29	29.65	26.67
ADON	24.39	22.67	21.12	19.67	21.12	18.73	27.45	27.45	27.45	26.14	22.67

2003 - Staffing and Occupancy Data

	State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
		1	2	3	4	5	6	7	8	9	10
Average Occupancy	80.80%	80.80%	80.60%	79.90%	80.60%	75.20%	82.00%	82.00%	82.00%	81.60%	80.80%
Medicaid Utilization	64.80%	56.40%	57.70%	59.60%	57.70%	62.80%	70.00%	70.00%	70.00%	64.30%	56.40%
Medicare Utilization	8.50%	7.50%	7.50%	7.70%	7.50%	8.70%	9.10%	9.10%	9.10%	9.30%	7.50%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2002 Cost Reports
2002 (Run June 1, 2004)

UN-INFLATED

Report		State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA		
Line	Description	1	2	3	4	5	6	7	8	9	10	11	10th %	90th %
1	Dietary	6.01	7.28	6.51	5.36	6.51	5.48	5.92	5.92	5.83	7.28	5.60	4.17	9.77
2	Food Purchase	4.27	4.52	4.40	4.15	4.40	3.99	4.31	4.31	4.31	4.11	4.52	3.29	5.90
3	Housekeeping	3.65	3.84	3.56	3.05	3.56	3.25	4.13	4.13	4.13	3.89	3.84	2.51	5.63
4	Laundry	1.90	2.15	2.01	1.72	2.01	2.09	1.67	1.67	1.67	1.58	2.15	1.10	3.13
5	Heat & Other Utilities	2.71	2.84	2.76	2.75	2.76	2.54	2.67	2.67	2.67	2.72	2.84	2.73	4.03
6	Maintenance	2.99	3.41	2.96	2.91	2.96	2.48	3.16	3.16	3.16	2.90	3.41	2.92	5.11
8	TOTAL GENERAL SERVICES	22.09	24.39	22.49	20.85	22.49	20.47	22.71	22.71	22.66	24.39	22.04	17.19	30.80
10	Nursing & Medical Records	40.68	42.79	42.10	37.44	42.10	33.35	43.96	43.96	43.96	43.84	42.79	41.16	62.04
10A	Therapy	1.85	1.90	2.38	2.86	2.38	1.81	1.54	1.54	3.02	1.90	2.27	-	10.03
11	Activities	1.88	2.12	1.89	1.50	1.89	1.37	2.23	2.23	2.23	2.10	2.12	1.60	3.39
12	Social Services	1.44	1.46	1.50	1.08	1.50	1.13	1.61	1.61	1.61	1.32	1.46	1.32	3.00
16	TOTAL HEALTH CARE & PROGRAMS	47.55	50.19	49.32	44.36	49.32	39.56	50.57	50.57	50.57	52.75	50.19	47.76	74.79
17	Administration	3.39	3.49	3.30	3.27	3.30	3.61	3.39	3.39	3.39	3.20	3.49	3.54	6.84
19	Professional Services	0.98	1.00	0.76	0.88	0.76	0.98	1.05	1.05	1.05	1.19	1.00	0.72	2.93
21	Clerical & Gen. Office Expense	4.58	4.07	4.40	3.67	4.40	3.47	5.75	5.75	5.75	4.19	4.07	4.31	10.72
22	Employee Benefits & PR Taxes	9.63	10.11	10.26	8.28	10.26	7.80	10.26	10.26	10.26	9.30	10.11	8.44	17.51
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.16	0.06	0.06	0.06	0.03	0.12	0.09	0.37
26	Insurance-Property, liability & Malpractice	2.19	1.93	1.97	1.87	1.97	2.00	2.46	2.46	2.46	2.40	1.93	2.03	3.92
28	TOTAL GENERAL ADMINISTRATIVE	23.47	23.64	24.80	21.32	24.80	20.28	25.17	25.17	25.17	23.10	23.64	21.93	36.02
29	TOTAL OPERATING EXPENSES	94.39	99.26	97.46	85.50	97.46	82.47	99.35	99.35	99.35	97.86	99.26	91.33	138.58
30	Depreciation	3.53	3.13	3.86	3.26	3.86	2.41	4.18	4.18	4.18	3.94	3.13	3.04	8.09
32	Interest	2.73	2.84	2.05	2.60	2.05	1.55	4.55	4.55	4.55	2.14	2.84	1.54	12.86
33	Real Estate Taxes	1.30	0.77	0.88	0.93	0.88	0.72	3.17	3.17	3.17	1.29	0.77	1.03	5.05
37	TOTAL OWNERSHIP	11.44	9.19	9.85	8.76	9.85	6.52	15.35	15.35	15.35	11.40	9.19	10.00	24.50
	TOTAL OPERATING & OWNERSHIP COST	105.83	108.45	107.31	94.26	107.31	88.99	114.70	114.70	114.70	109.26	108.45	101.30	163.08

Cost Report														
Line	Description													
1	Dietary	6.01	7.28	6.51	5.36	6.51	5.48	5.92	5.92	5.83	7.28	5.60	4.17	9.77
2	Food Purchase	4.27	4.52	4.40	4.15	4.40	3.99	4.31	4.31	4.31	4.11	4.52	3.29	5.90
3	Housekeeping	3.65	3.84	3.56	3.05	3.56	3.25	4.13	4.13	4.13	3.89	3.84	2.51	5.63
4	Laundry	1.90	2.15	2.01	1.72	2.01	2.09	1.67	1.67	1.58	2.15	2.23	1.10	3.13
5	Heat & Other Utilities	2.71	2.84	2.76	2.75	2.76	2.54	2.67	2.67	2.72	2.84	2.73	1.89	4.03
6	Maintenance	2.99	3.41	2.96	2.91	2.96	2.48	3.16	3.16	2.90	3.41	2.92	1.95	5.11
8	TOTAL GENERAL SERVICES	22.09	24.39	22.49	20.85	22.49	20.47	22.71	22.71	22.66	24.39	22.04	17.19	30.80
10	Nursing & Medical Records	40.68	42.79	42.10	37.44	42.10	33.35	43.96	43.96	43.84	42.79	41.16	26.11	62.04
10A	Therapy	1.85	1.90	2.38	2.86	2.38	1.81	1.54	1.54	3.02	1.90	2.27	-	10.03
11	Activities	1.88	2.12	1.89	1.50	1.89	1.37	2.23	2.23	2.10	2.12	1.60	1.13	3.39
12	Social Services	1.44	1.46	1.50	1.08	1.50	1.13	1.61	1.61	1.32	1.46	1.32	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	47.55	50.19	49.32	44.36	49.32	39.56	50.57	50.57	52.75	50.19	47.76	31.31	74.79
17	Administration	3.39	3.49	3.30	3.27	3.30	3.61	3.39	3.39	3.20	3.49	3.54	1.65	6.84
19	Professional Services	0.98	1.00	0.76	0.88	0.76	0.98	1.05	1.05	1.05	1.19	1.00	0.07	2.93
21	Clerical & Gen. Office Expense	4.58	4.07	4.40	3.67	4.40	3.47	5.75	5.75	5.75	4.19	4.07	2.36	10.72
22	Employee Benefits & PR Taxes	9.63	10.11	10.26	8.28	10.26	7.80	10.26	10.26	9.30	10.11	8.44	6.22	17.51
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.16	0.06	0.06	0.03	0.12	0.09	-	0.37
26	Insurance-Property, liability & Malpractice	2.19	1.93	1.97	1.87	1.97	2.00	2.46	2.46	2.40	1.93	2.03	0.83	3.92
28	TOTAL GENERAL ADMINISTRATIVE	23.47	23.64	24.80	21.32	24.80	20.28	25.17	25.17	23.10	23.64	21.93	16.13	36.02
29	TOTAL OPERATING EXPENSES	94.39	99.26	97.46	85.50	97.46	82.47	99.35	99.35	97.86	99.26	91.33	67.15	138.58
30	Depreciation	3.53	3.13	3.86	3.26	3.86	2.41	4.18	4.18	3.94	3.13	3.04	0.73	8.09
32	Interest	2.73	2.84	2.05	2.60	2.05	1.55	4.55	4.55	2.14	2.84	1.54	-	12.86
33	Real Estate Taxes	1.30	0.77	0.88	0.93	0.88	0.72	3.17	3.17	1.29	0.77	1.03	-	5.05
37	TOTAL OWNERSHIP	11.44	9.19	9.85	8.76	9.85	6.52	15.35	15.35	11.40	9.19	10.00	3.55	24.50
	TOTAL OPERATING & OWNERSHIP COST	105.83	108.45	107.31	94.26	107.31	88.99	114.70	114.70	109.26	108.45	101.30	70.70	163.08

2002 - Average Wage Data Table

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
Line	1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nursing per diem	5.20	5.50	5.40	5.00	5.40	5.10	5.00	5.00	4.90	5.50	5.30
Nursing hours including contract nurses per diem	2.80	3.10	3.10	3.00	3.10	2.90	2.60	2.60	2.60	3.10	3.00
RN	20.69	20.12	19.18	18.37	19.18	16.06	23.49	23.49	23.49	21.31	19.45
LPN	16.89	17.04	15.72	14.33	15.72	12.75	19.39	19.39	19.39	17.96	15.69
CNA	9.73	10.05	9.65	9.09	9.65	8.08	10.28	10.28	10.28	10.39	9.62
DON	26.38	24.75	22.98	22.48	22.98	20.02	31.78	31.78	31.78	28.56	23.68
ADON	23.27	21.44	20.51	18.93	20.51	17.26	26.34	26.34	26.34	24.33	21.27

2002 - Staffing and Occupancy Data

	State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	
		1	2	3	4	5	6	7	8	9	10	11
Average Occupancy	80.90%	79.60%	81.90%	80.30%	81.90%	75.30%	82.20%	82.20%	82.20%	82.00%	79.60%	76.60%
Medicaid Utilization	64.50%	55.50%	56.10%	58.50%	56.10%	63.30%	69.90%	69.90%	69.90%	66.70%	55.50%	60.90%
Medicare Utilization	7.40%	6.80%	7.20%	6.10%	7.20%	7.40%	7.70%	7.70%	7.70%	8.20%	6.80%	7.00%